Managed Risk Medical Insurance Board
April 17, 2013, Public Session

Board Members Present:	Clifford Allenby, Chairperson Richard Figueroa Samuel Garrison Ellen Wu
Ex Officio Members Present:	Jack Campana, Chairman of the Healthy Families Advisory Panel Robert Ducay, Designee for the Secretary of the California Health and Human Services Agency Shelley Rouillard, Designee for the Secretary of the Business, Housing & Transportation Agency
Staff Present:	Janette Casillas, Executive Director Terresa Krum, Chief Deputy Director Laura Rosenthal, Chief Counsel, Legal Tony Lee, Deputy Director, Administration Ernesto Sanchez, Deputy Director, Eligibility, Enrollment & Marketing Jeanie Esajian, Deputy Director, Legislative & External Affairs Ellen Badley, Deputy Director, Benefits & Quality Monitoring Morgan Staines, Senior Staff Counsel, Legal Jenny Phillips, Staff Counsel, Legal Rebecca Dietzen, Senior Staff Counsel, Legal Carmen Fisher, Associate Government Program Analyst, Legal Muhammad Nawaz, Manager, Benefits & Quality Monitoring Tiffany Henderson, Analyst, Benefits & Quality Monitoring Amanda Evans, Manager, Administration Loressa Hon, Manager, Administration Laurie Herrera, Manager, Administration Larry Lucero, Manager, Eligibility, Enrollment & Marketing Carol McCants, Manager, Eligibility, Enrollment & Marketing Maria Angel, Executive Assistant to the Board and the Executive Director Eubelle Agulto, Board Assistant
Also Present:	René Mollow, Deputy Director, Health Care Benefits & Eligibility, California Department of Health Care Services
Public Comment:	Elizabeth Abbott, Health Access Kelly Hardy, Children Now Hellan Roth Dowden, Teachers for Healthy Kids

Chairman Allenby called the meeting to order at 10:05 a.m. The Board went into Executive Session and resumed public session at 11:02 a.m.

REVIEW AND APPROVAL OF FEBRUARY 20, 2013 PUBLIC SESSION

The minutes of the February 20, 2013 public session were approved as submitted.

The February 20, 2013, Public Session Minutes are located at: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_3_Public_Minutes_2-20-13_Final.pdf

STATE BUDGET UPDATE

Update on the Healthy Families 2012-13 Shortfall

Tony Lee reported on Agenda Item 4.a, Update on the Healthy Families 2012-13 Shortfall. MRMIB received $15 million from the Contingencies or Emergencies Fund and used this to pay all but two HFP plans for December, as well as the administrative vendor. MRMIB is still awaiting a supplemental appropriation of approximately $125 million which, when received, will allow all other payments to be made.

Richard Figueroa asked if the shortfall amount reported was General Fund. Mr. Lee said that was correct. Mr. Figueroa noted that the shortfall including the federal match would be three times that amount. Mr. Lee said that also was correct.

Mr. Figueroa said HFP plans are doing the best they can and continuing to provide service to subscribers without being paid. The shortfall is very large. He said it was distressing for the Board to be in this situation.

Chairman Allenby asked if there were other comments or questions. There were none.

Budget Hearings

Mr. Lee reported on Agenda Item 4.b, Budget Hearings. The Senate Budget Subcommittee No. 3 met on Thursday, April 4. He indicated that, at the hearing, staff provided an overview of MRMIB's programs, the HFP shortfall and the future of PCIP, MRMIP and AIM. The Department of Health Care Services provided an update on the transition of HFP subscribers to Medi-Cal. During the hearing, legislative and public concerns were expressed regarding the lack of access to autism services, including ABA (Applied Behavioral Analysis) services, for transitioned HFP subscribers. Members of the public who testified complained that the transition was originally presented as offering more services, not fewer.

An Assembly Budget Subcommittee No. 1 hearing is scheduled for April 22.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

Analysis of Governor's Proposed Budget by the Legislative Analyst Office

Mr. Lee reported on Agenda Item 4.c, Analysis of Governor's Proposed Budget by the Legislative Analyst Office. The full LAO analysis of the Governor's 2012-13 budget proposal includes a section on the HFP transition, beginning on page 10. The analysis provides a brief overview of HFP, discusses the transition timeline and phases and the erosion of assumed General Fund savings in the current budget year and years that follow. The LAO also noted a decline in HFP caseload for the period of May 2012 to December of 2012.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The Analysis of the Governor's Proposed Budget by the Legislative Analyst Office is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_4.c_--_LAO_2013-14_Governor%27s_Budget_Analysis.pdf

Other State Budget Issues
Janette Casillas said there were no other State Budget Issues to report.

TRANSITION OF THE HEALTHY FAMILIES SUBSCRIBER TO THE MEDI-CAL PROGRAM

Update on Staff Transition

Ms. Casillas reported on Agenda Item 5.a, Update on Staff Transition. MRMIB and DHCS have mutually agreed to the first phase of staff transition, which will move 20 positions to DHCS. Ten of these positions are vacant and 10 are filled by incumbents. These 20 positions will transition on May 15. Transitioned staff were given notice, as were the unions, and MRMIB staff is working with these employees to answer questions about their new work location, duties, new supervisors and new assignments. DHCS staff will come to MRMIB and meet with the 10 staff members on April 23.

Additionally, Ms. Casillas said it was her understanding that DHCS is working on a second phase of MRMIB staff transition by assessing additional work needs required by CMS to monitor and report on the transition of HFP children to the Medi-Cal Program. MRMIB submitted a required staff transition plan to the Legislature on April 9, identifying the first phase of staff transition and indicated that a second phase will be forthcoming as DHCS conducts a needs analysis.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

Update on Transition of Phase 1A, 1B, 1C and 2 Subscribers to Medi-Cal

Ms. Casillas reported on Agenda Item 5.b-e, Update on Transition of Phase 1A, 1B, 1C and 2 Subscribers to Medi-Cal. Slightly more than 178,000 Phase 1A subscribers transitioned on January 1. These were children who retained the same health plan and primary care provider, with few exceptions. Just over one percent

or 1,850 of these children were required to select a new primary care provider. On March 1, a second group of just over 106,400 children moved from HFP to Medi-Cal; all of them remained in the same health plan. In this group, a larger number of children, 8,039, were required to change primary care providers. On April 1, slightly more than 270,000 HFP children transitioned to Medi-Cal, leaving HFP with an enrollment today of 224,000 children.

After reviewing grievances and complaints in the monitoring reports, Ms. Casillas recommended the data also take into account calls and complaints made to either the Department of Managed Health Care's help line or the Maximus Single Point of Entry call center. Because of the few grievances and complaints noted in the monitoring reports, Ms. Casillas said she presumed there are probably a lot more phone calls in this area that are not being captured probably because of the systems in place. Because of the transition, Maximus anticipated a 25 percent increased call volume through the SPE call center, and increased staffing to handle the anticipated increase. With an additional 25 percent call volume, she said, it is difficult to imagine there were not more grievances, complaints or inquiries that fall within the scope of the report.

Ms. Casillas indicated that DHCS reported, on April 3, that 418 HFP children who transitioned had already received Medi-Cal specialty mental health services. She indicated that, while it is good to know these children are finding the services, the delivery systems and the process to either obtain or continue receiving these services, those numbers also appear significantly low. In HFP, it is the health plan that delivers most mental health services. Only serious emotional disturbances-related services are carved out to county mental health departments. Therefore, many more than 418 children within HFP received mental health services. The report also indicates that DHCS is closely tracking its Mental Health Ombudsman line. As more children are transitioned to Medi-Cal, more calls are being directed to that line. The reported calls were 103 in January, 39 in February and 196 in March. Ms. Casillas explained that this is an area where MRMIB would encourage DHCS to include data or inquire about the DMHC help line to see whether calls of that nature are being received.

Ms. Casillas said it was her understanding that the DMHC call center has a very sophisticated tracking and coding system through which to obtain a better assessment of mental health services. The DHCS April monitoring report contained a small notation on autism, specifically Applied Behavioral Analysis or ABA services. This issue is being raised more frequently and came up in the MRMIB budget hearings last year. There were adjustments to the budget for the Regional Centers to exclude HFP children from receiving services at Regional Centers and, instead, redirect that service as a responsibility of HFP health plans. It was shortly after that that the action to transition HFP children to Medi-Cal took place.

Chairman Allenby noted that Medi-Cal uses the Regional Centers. Ms. Casillas said that was correct, but said it does not appear that all of the Regional Center services are available to Medi-Cal children, and if they are available, the delivery system for these services is not clear. Ms. Casillas recommended that this issue be called out in the monitoring reports under Mental Health Services, even if there is more work to be done and more questions to be researched and analyzed, so it is acknowledged as an outstanding issue much more broadly than it is currently.

The monitoring report section on Dental Services provides statistics on prior authorizations. Ms. Casillas said this appears to be significantly understated. There are no descriptions of activities or efforts undertaken by DHCS to acquire the prior authorizations that may have been pending while the children were still in HFP. MRMIB surveyed HFP dental plans to determine the number of prior authorizations that were outstanding and transmitted those numbers to DHCS. She said MRMIB would make sure those prior authorizations were received by DHCS in advance of subscriber transitions and not after the fact.

Mr. Figueroa asked Ms. Casillas whether she was stating that the number of prior authorizations MRMIB had obtained did not match the number reported by DHCS. Ms. Casillas said that was correct.

Ms. Casillas said it was her presumption that former HFP children were trying to find their way in the Medi-Cal system. She said she didn't know whether they transitioned from dental managed care to dental managed care, or whether they transitioned from dental managed care to Denti-Cal fee-for-service. She had total numbers by plan, not by child. However, this would be an area in which some improvements could be made to services that were previously assessed, authorized and needed, and she indicated that it would be possible to do a better job of building a bridge so these families can learn the new system, and understand where to get services that were already identified as being needed.

Ms. Casillas said that four grievances were reported by former HFP subscribers for dental services from January through March under the Denti-Cal program. This would be another area about which DHCS could include data from the Maximus call center to see whether any grievance calls that needed to be redirected to Denti-Cal or elsewhere were going there. In the area of dental customer satisfaction, Ms. Casillas recommended that DHCS look at hiring someone to conduct an independent consumer survey of transitioned children for both its managed care and fee-for-service dental systems. Such a survey could help with priorities if many different areas are identified that need improvement. The focus could be on the type of service, such as pediatric or regular dentistry, or dentists by language. Independent surveys of children, even in the fee-for-service system, would provide insights.

Chairman Allenby recalled that when MRMIB began managed care dental services there were significant problems in the beginning in providing services, so it could be assumed these issues were not going away because the services and subscribers are moving to Medi-Cal.

Ms. Casillas said that this speaks to increased monitoring, reporting and performance standards. At least in the Sacramento area, and possibly Los Angeles, the new Medi-Cal contracts with dental plans are much more aggressive than in the past concerning performance standards and reporting. A recent report showed an improvement in the number of children that were accessing Medi-Cal dental services. While she had not reviewed the entire report or the data, Ms. Casillas said the outcomes indicated improvement.

Other Board documents provide an overview of the various transition phases by numbers of children affected, counties and plans. The documents describing Phases 1A and 1B represent the actual number of children, not the budgeted numbers.

Mr. Figueroa asked whether the difference between the September budgeted transition of 197,241 children and the 178,000 children that actually transitioned January 1 was due to the fluctuation of children enrolling and disenrolling during that period of time. Ms. Casillas said that this was correct and that the September enrollment was provided only because it was noted in the original budgets and in DHCS's original transition plan.

Mr. Figueroa asked whether the 178,113 children were sent letters regarding the transition. Ms. Casillas said they were. Mr. Figueroa asked whether those children were successfully transitioned with a health plan and primary care provider. Ms. Casillas said that this was the case.

Ms. Casillas went on to address a report in the Board packet that showed what is called the "tail," depicting some of the children who should have gone to Medi-Cal in the Phase 1, but did not because they did not receive a transition notice, likely because they enrolled in HFP late. Ms. Casillas said MRMIB staff agrees with DHCS that the notice is a priority; if a subscriber did not receive a notice, as required by statute, he or she will not be transitioned until a later phase or the so-called "tail." Individuals in the tail of Phase 1A were transitioned on March 1 because they had not received the notice in time for the January 1 transition. She said the numbers provided to the Board for children transitioned in Phase 1C, set for April 1, were budgeted numbers, not actual numbers, which are not yet available. She said that HFP plans have indicated that this does not make sense to them Health plans have been told that these children remain because they did not receive the notice and that they will be transitioned in a later phase after receiving due notice.

Mr. Figueroa asked whether, for these children who received their benefit identification card (BIC) and are enrolled in Medi-Cal, DHCS accepted the determination process from HFP for the renewal date of these children. Ms. Casillas said that this was correct. Mr. Figueroa asked whether the renewal date of these former HFP children now in Medi-Cal would coincide to a year from the time they were first enrolled in HFP. Ms. Casillas said that this was correct.

Mr. Figueroa asked whether Medi-Cal would be able to obtain enrollment data and use a special aid code for transitioned children whose renewal was between February and April. He noted that these children would have higher federal funding than other Medi-Cal beneficiaries. He asked how these children would be tracked. René Mollow said that these children did have a special aid code that would allow Medi-Cal to track them.

Mr. Figueroa asked whether Medi-Cal would be able to check over time on renewal rates and the number of former HFP children who stayed in Medi-Cal and whether Medi-Cal could use that information to see whether former HFP subscribers were leaving Medi-Cal at an inordinate rate and how many actually stayed. He said he feared that tens of thousands of HFP children have been or

will be lost in the transition process, because of disenrollment, not completing their annual eligibility review or confusion. Ms. Casillas concurred with Mr. Figueroa.

He said his interest was in using Medi-Cal data to track the former HFP children by aid code over time so that researchers, the Legislature, the public and others could gain an understanding of how the transition worked, whether subscribers left Medi-Cal and what the end result was. Mr. Figueroa said he would be curious to see the tracking data that Medi-Cal is providing to the Legislature or public or posting on a website. He asked whether this data would be available in the May Revision.

Ms. Mollow said that former HFP subscribers have a specified aid code when they transition and that there are two basic aid codes. They identify subscribers based on whether or not they pay a premium, which is based on the subscribers' FPL (federal poverty level). Upon re-determination of eligibility, these children will be enrolled in the DHCS Targeted Low-Income Children's Program aid code, which is actually an H aid code, of which there are approximately five. Codes are based on income levels and ages. The numbers were identified and are being viewed over the course of the transition in order to report to Centers for Medicare and Medicaid Services (CMS) and the Legislature. Mr. Figueroa asked whether the former HFP subscribers would transition to Medi-Cal in one aid code and then transition into one of the new H codes. Ms. Mollow said that this was correct and that the goal was to rely on the determination made by MRMIB, unless there is a change in the circumstances of the subscriber that requires transition into a different aid code. Mr. Figueroa said that the explanation was helpful.

Jack Campana asked Ms. Mollow whether, in addition to transition data, the Board would also be able to view new enrollment data. He said his interest was in response to concerns in the report about declining HFP enrollment over the last year. For eligible new enrollees who meet the old HFP criteria, this information should be available, because this is what has enabled them to be transitioned into Medi-Cal. He asked when the Board could see this information.

Ms. Mollow said that, beginning January 1, applications were being assessed as they are submitted through either SPE or the counties. She said a challenge with Medi-Cal is that, when eligibility determinations are made, because of the array of programs and eligibility pathways for individuals, there is an effort to put applicants in the most advantageous program under Medi-Cal, with the goal of starting with no-cost full-scope Medi-Cal eligibility. Medi-Cal will look at the new cases, whether they come through SPE or the counties, to see whether there are differences in enrollment for the existing 1931(b) program for children and families or in the Targeted Low Income Program, beyond what would have been anticipated. Because of the way some income eligibility calculations work, both of the parallel pathways to enrollment will be assessed.

Mr. Figueroa asked Ms. Mollow to explain the difference between the new system and the old system, under which a child at SPE was checked for Medi-Cal eligibility and sent to the county, if eligible for Medi-Cal. Ms. Mollow said the only difference will be that now the system will look at whether an application includes family members or is an application for a child only; if the latter, the child will be placed in the children's program. She said the same would hold true for an application submitted to a county.

Mr. Figueroa asked when trend information would become available on the transition and the 5-H category level. Ms. Mollow said that this would likely be after the transition is completed because of the eligibility determination process. She said she has been working on trying to provide interim information, a snapshot perhaps, in the first three months.

Mr. Figueroa noted that the DHCS website provides information on eligibility overall, which carries a warning that there is a six or eight-month completion factor involved. However, he said he would prefer not to wait until the entire transition is completed to gain an understanding of what has happened.

Chairman Allenby asked if there were any further questions or comments from the Board or the audience. There were none.

Subscribers to the Medi-Cal Program are located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_5.pdf

Call Center Report

Ms. Casillas reported on Agenda Item 5.f, the Call Center Report. She noted the bump in calls in January, which totaled nearly 22,000 calls related to transition. This number rose to just over 23,000 in March.

The Call Center Report is located at:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_5.f._--_HFP_Call_Center_Report_4-10-13.pdf

Transition versus Disenrollment Statistics

Ms. Casillas reported on Agenda Item 5.g, Transition versus Disenrollment Statistics. This report shows how the transition affected enrollment and includes the period from December and January. The focus was specifically on whether disenrollment due to nonpayment and member request was increasing, as suspected.

This report also shows the number of children transitioned each month in comparison to the number of children disenrolled for each month. The second page of the report shows a decline and then large increase over time in non-payment of premium. There are two bullet-points at the bottom of the chart to make sure disenrollment data is not taken out of context. The third page of the report also provides raw data that indicates the increase in disenrollments is more attributable to the annual eligibility review process, with more applications sent to Medi-Cal because of new 1831(b) rules implemented in January than to a problem.

Ms. Casillas said the data called out in the HFP enrollment report and the disenrollment report will continue to be tracked and shared with the Board.

The Transition versus Disenrollment Statistics can be found at:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_5g_Transitions_vs._Disenrollment_Statistics.pdf

2012 Application Volumes by Month

Ms. Casillas reported on Agenda Item 5.h, 2012 Application Volumes by Month. The report was provided because of numerous questions about application volumes when MRMIB was administering SPE and enrolling children into HFP. This report provides data on the volume of applications received at SPE for each month of the calendar year 2012.

This report can be used as a comparison point in reviewing Medi-Cal monthly monitoring reports. In most cases, Ms. Casillas said she believed Medi-Cal was using MRMIB data and comparison points.

The 2012 Application Volumes by Month is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_5.h._--_2012_Application_Volumes_by_Month.pdf

Updated Schedule of Subscriber Notices

Ms. Casillas presented Agenda Item 5.i, which is a revised version from the original. It is a table that contains the schedule of subscriber notices. The only change in the revised document is a new row added for the secondary Phase 1C, which is the Health Net transition in Los Angeles and San Diego counties.

The transition of those children was delayed for one month to allow Health Net to reach out to HFP families to encourage parents to make their own selection of a primary care physician because their current physician would not be available after the transition. For parents who did not select a new primary care physician, one will be assigned to their child. Additionally, parents can always change physicians, even on a monthly basis.

The Updated Schedule of Subscriber Notices is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_item_5.i_Notices_Schedule.pdf

Transition of the Healthy Families Program Advisory Panel to the Department of Health Care Services

Ms. Casillas reported on Agenda Item 5.j, Transition of the Healthy Families Program Advisory Panel to the Department of Health Care Services. MRMIB staff coordinated the last two meetings with Ms. Mollow present. Ms. Mollow has met and addressed the Panel, and heard some of their concerns on various topics. MRMIB staff provided a binder with all Panel protocols used in preparing agendas, agenda topics and public notice of the year's meeting schedule. The next two meetings of the year will have a change of location, moving to a meeting room across the street from the DHCS building.

Chairman Allenby asked Mr. Campana his thoughts about the Panel's transition. Mr. Campana said the Panel has discussed what it is going to look like in the future. At the May meeting, this will be discussed with Ms. Mollow, in terms of the Panel's continued contribution, changes that may occur and what role DHCS sees for the Panel.

Ms. Casillas said the meeting location near DHCS will facilitate access to the DHCS management team, so they can meet and engage with the Panel. She said MRMIB staff will continue to lead efforts on developing the agendas and agenda materials for the rest of this calendar year and provide assistance, as needed, to Ms. Mollow in developing next year's calendar. As of 2014, DHCS will assume full responsibility for the administration of the Panel.

Questions and Answers with Department of Health Care Services Representative

Chairman Allenby asked if there were any additional questions for Ms. Mollow under Agenda Item 5.h.

Beth Abbott of Health Access encouraged Ms. Mollow to take Ms. Casillas' suggestion and include data drawn from other sources where subscriber complaints could be registered. She said the public does not understand complaint processes well, and will most often complain to a daughter or neighbor because they do not know exactly where to register complaints. She said DMHC probably has the best-known complaint tracking and organizational reporting system, and is a place where DHCS would likely find some addition complaints about the transition. She urged Ms. Mollow to look at that because complaints are not easily categorized. Subscribers are not specific, such as "I'm calling about the Healthy Family Program to Medi-Cal transition." They would complain that they cannot get a doctor or are having problems navigating a system.

Additionally, Ms. Abbott cautioned that the state should not congratulate itself on the perfection of the transition based on the low number of complaints. Feedback will have to be ferreted out. She applauded efforts to move the HFP Advisory Panel to a larger venue and said it was good for DHCS managers to hear the Panel's public discussions, noting that this venue was another way to hear subscriber complaints.

She seconded Ms. Casillas' suggestion that DHCS survey transitioned subscribers as a more organized way to gather input on how the transition went. Ms. Abbott said she and others want as close to universal coverage as possible for Californians. There are very high numbers of uninsured Californians and the unfortunate timing of this transition may contribute to people's not having the health care that they have been accustomed to. Many families were very pleased and appreciated their enrollment in HFP and wanted that to continue and extend, both for the children and families in Medicaid, and for people who are joining Medicaid.

She indicated that it would be important to research how the transition worked and whether it led to HFP subscribers being lost in the transition, in order to determine whether outreach or other efforts would help bring those people back into the program. She indicated the importance of having more people insured, more people getting care and more people having coverage, regardless of all of this turmoil.

Ms. Abbott said she had attended numerous meetings regarding the Healthy Families transition to Medi-Cal and is in the process of reading the two reports,

with comments due Monday. She said Ms. Casillas' comments understate the "holy mess" of the transition of mental health behavioral services. She characterized it as "unspeakably bad" and said that nobody – not the health plans, the Regional Centers, DHCS, the California Health and Human Services Agency or HFP – wants it to be like this.

She recounted that she told Agency officials who were running the meeting that it gives her a headache to hear how a family would have to negotiate to get services for a child because of carve-outs. The plans are trying to give notices to families to whom they will no longer be providing services. Ms. Abbott said Regional Centers are confused and plans do not understand why they are not getting paid for providing these services. She asked Ms. Mollow to look very carefully at this issue because it is not going well.

Ms. Abbott expressed the view that, under a continuity of care exception in state law, if a subscriber is in the middle of a course of treatment for a serious condition, the subscriber does not have to be transitioned, in some cases, for up to 12 months. She stated that, in the case of a newborn, it is up to 36 months. She said that, when she called this exception to the attention of state officials, she was told publicly that the reason that the transition notification letters did not include an explanation of this to families was that it was too complicated for families to understand.

She said this exception was particularly important in this phase of the transition because these subscribers are very likely to have some disruption in their plan and doctor. Ms. Abbott said she was told that it was the health literacy consultant that said the explanation on continuity of care was too complicated for families to understand. She said that, even if that was true, it does not provide a rationale for eliminating that provision from the letter. She stated that this is not an optional provision in state law. Ms. Abbott said DHCS must work harder on what the notices contain because continuity of care is absolutely a fundamental consumer right.

Hellan Roth Dowden, representing Teachers for Healthy Kids, said her group was meeting with people working with school districts around the state, and in particular, the Inland Empire, to discuss how the transition was going. Through the meetings, she said her group learned that families do not want to go on Medi-Cal, and may not renew when renewal comes due. She said that families also erroneously believe that, when the full provisions of the Affordable Care Act take effect, they will be eligible for that. There is a lot of misinformation among parents and there is a need to get the word out to parents that this is a good program and you need to keep your children enrolled. Her group is trying to determine how to reach parents and change their attitudes about Medi-Cal and educate them so they do not have big gaps in treatment for their children.

Through the meetings, Ms. Dowden's group also heard input that webinars should be held by areas of the state because, when families listen in, the webinars do not contain any information specific to them and are too broad. She suggested a webinar just for the Inland Empire, or one for Los Angeles. She suggested that, if DHCS were to do a webinar just for the Inland Empire or for Los Angeles, it would be really helpful, because the more general discussion does not answer their questions and they do not know exactly how to ask their questions.

Ms. Dowden noted that dental coverage, a third area of concern raised in the meetings, is a continuing area of concern for Teachers for Healthy Kids. Participants in a dental webinar were told that 7,400 beneficiary calls resulted in appointments for 300 children. When Teachers for Healthy Kids asked Medi-Cal what happened to the other 7,100 calls, they were told that it was possible not all the calls were requesting appointments. However, there is very little evidence-based data on exactly what happened to those children, and Teachers for Healthy Kids is continuing to hear that there is a problem with access. These families cannot call Health Net anymore and are trying to get through on a state phone number; that takes a long time.

Ms. Roth Dowden said Teachers for Healthy Kids still has many concerns about the transition, especially now that the upcoming phases are going to be much tougher. It is not going to be so much of a one-to-one transition as in the prior phases

Kelly Hardy with Children Now and a coalition including the Children's Defense Fund, Children's Partnership, United Way, California Coverage and Health Initiatives, and PICO California, said she wished to emphasize Ms. Casillas' recommendations outlined in the report. She also seconded Beth Abbott's concerns about the mental health system; she noted that Children Now and the coalition have been working with autism advocates and have collected a dozen stories out of the more than 200 families that have been affected by the ABA therapy issue. She said it was heartbreaking to see the lengths to which these parents have gone to try to maintain continuity of services for their children.

Ms. Hardy said these children really need continuity of services and the coalition believes that the transition should be suspended until this problem is fixed and the state can guarantee that no more children will experience this kind of disruption in services.

Ms. Hardy then addressed the dental issue, which she indicated is a real one. She stated that dental issues are showing up in a more delayed manner because children do not immediately need to see a dentist; except typically they see a dentist at most twice a year. She indicated that this is why the state is not seeing urgent dental issues. She recounted a story from one father who took his son to urgent care on April 14. The son had been transitioned on April 1. The father was told that his son had no coverage; Ms. Hardy stated that this is not the time a parent wants to be given this kind of information. Because this story came to a coalition partner, action was taken to contact a very helpful plan representative and the coverage was reinstated right away. Ms. Hardy said her group hears about these "canaries in the coal mine" and wonder what is happening to other people.

Chairman Allenby asked if there were any additional comments from the audience.

Mr. Figueroa said he thinks the transition happened for no good reason, did not have to happen and has been rushed for no good reason. He said it was known back in October and November that the transition of mental health services was going to be a mess and that the dental access issues were known; the issue was not just the transferring of the data. He indicated that this was seen coming a long

time ago. Now DHCS has to work with the counties and plans to figure out how to make it better.

Mr. Figueroa said that the Board is able to look at the transition progress and how the former HFP children are faring. However, in other areas, the Board is limited in its actions, whether it be a survey of transitioned subscribers, or access to ABA or dental services. However, the Board can review the data pre- and post-transition to see what has happened. The Board also can assist, as possible, on the continuity of care issue. Whether it be future notices, or something else, the Board can continue to help with improvements to the transition.

He said the Board was trying to keep faith with the families that first enrolled in HFP about the kind of services they have come to expect.

Chairman Allenby asked if there were further comments. Ms. Mollow said she would like to comment.

She said DHCS takes the work of transitioning the children to the Department very seriously, and has been working closely with plan partners and providers on the issues that have been coming to our attention. As part of the special terms and conditions with CMS, DHCS conducted a beneficiary survey. Approximately 10,000 calls were made with a very small return of people responding to the survey. Those that responded reported favorably on their experiences to date with the program, and in accessing both health and dental services. The survey will be an ongoing process as we move forward through each of the phases.

Ms. Mollow stated that the dental program has seen an increase in claims from former HFP children transitioned to Medi-Cal. Those increases, in claims and utilization of services, are higher than what DHCS sees in the comparable Medi-Cal population. As DHCS continues to receive inquiries, staff continues to work hard on follow-up and issue assessment, and on working with plan partners when inquiries deal specifically with health care services.

She indicated that DHCS is continuing to work on autism with health plans, and is working with MRMIB and obtaining information on what services have been provided in the past to obtain a better understanding regarding ABA services. Children in Medi-Cal have historically obtained ABA services through the Regional Center system. Ms. Mollow explained that the criteria for some of the early start services are different for Medi-Cal and are based on an identified need to access ABA services available under the Developmentally Disabled Waiver currently in place or through the Regional Centers. She said DHCS has been engaging with colleagues at the Department of Developmental Services, the Department of Managed Health Care and MRMIB to get a better sense of the areas in which children have access, where they may not have access because of eligibility criteria for different service pathways and the next potential steps within the Medi-Cal Program.

Ms. Mollow said DHCS has also been working with CMS on this because it is not just an issue for California, but is a nationwide issue. She said DHCS has been working very closely with partners, through control agencies and state partners in looking at the issue of ABA services, and appreciates the feedback to date regarding affected families.

Chairman Allenby asked if there were further comments.

Ms. Abbott said she does not question the intention or diligence of DHCS, but noted that accessibility of data does not equal the standard that advocates and the public are used to seeing. She asked where she could access the DHCS consumer survey. Ms. Mollow said it was on the DHCS website. Ms. Abbott said it has not been easy to find items posted to the DHCS website. She urged Ms. Mollow to have results of the survey highlighted in some way so they can be found. Ms. Abbott said the manner in which Ms. Mollow characterized the survey, which may have rolling results on access to care and subscriber experience with the transition, may lead to emerging patterns that would be excellent for advocates and the public to see.

Ms. Mollow said there is a link on the DHCS front page for Healthy Families Transition. She said she would follow-up with staff to determine how certain elements may be more prominently displayed.

Ms. Casillas suggested that the DHCS survey report be agendized for a future Board meeting. Chairman Allenby said it would be added.

Ms. Wu noted that HFP surveys get good return rates and wondered if there were best practices MRMIB could share with DHCS to assist in their survey return rates. She said CAHPS translated survey instruments help with return rates. Ms. Casillas said staff would be happy to share with DHCS some of the ways MRMIB has conducted surveys, methodologies used, follow up, language and contractors used to see if there was something DHCS may be interested in adopting.

Other HFP Transition Issues

Other HFP Transition Issues were not reported to the Board.

EXTERNAL AFFAIRS UPDATE

Jeanie Esajian reported on Agenda Item 6, the External Affairs Update. The report incorporates the last 60 days instead of the usual 30 days, because of the cancellation of the previous Board meeting.

While it was a light media period with regard to media requests, there continued to be a significant level of coverage regarding the transition of HFP subscribers to Medi-Cal. Coverage also focused on the Pre-Existing Insurance Plan's closure to new enrollment. The Board packet included a representative sample of the coverage.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

Ms. Esajian added that an article in California Healthline the morning of the Board meeting indicated that Republicans in the House were trying to provide additional funding from another source to reopen enrollment in the Pre-Existing Condition Insurance Plan.

Mr. Figueroa said the source of the funding was the Prevention of Public Health Fund.

The document on the External Affairs Update is located at:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_6_041713.pdf

STATE LEGISLATION

Ms. Esajian reported on Agenda Item 7, State Legislation. A total of 15 bills were added to the State Legislative Report since the last Board meeting. These new bills are identified in the usual way, with an asterisk. Eight bills were amended since last month and a tilde sign indicates those bills; strikeouts and underlines are used to make clear what has changed.

Staff has been closely watching two Special Session market reform bills: ABX1-2 and SBX1-2. These two bills have progressed since the last Board meeting.

Ms. Esajian stated that ABX1-2 was passed by the Senate Appropriations Committee in a 7-0 vote and now was moving to the Senate floor, where it was scheduled for a third reading the day after the Board meeting. ABX12 had been in in Assembly Appropriations the morning of the Board meeting and had just passed out on a roll call vote with no opposition. As described in the Legislative Report, these two bills are no longer identical, but are still tied together; in other words, they will only become operative if both are enacted and take effect.

Ms. Esajian stated that Special Session Bill XB1-3, allowing Covered California to establish a bridge plan, had also progressed. Bridge plans are designed to ease the transition for families who move in and out of eligibility for Medi-Cal based on income. The previous week the Senate passed SBX1-3 to the Assembly floor on a vote of 37 to 0.

SB 617 was amended since the Legislative Report in the Board packet was completed, and the changes will be reflected in the subsequent month's report. The amendment addresses appeals in the Exchange and within state health subsidy programs, including HFP and AIM.

Ms. Esajian also provided the Board with upcoming legislative deadline dates. Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The document for State Legislation is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_7_Legislative_Summary_4-17-13.pdf

PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) UPDATE

Update on Extension of Federal Contract

Ms. Casillas reported on Agenda Item 8.a, Update on Extension of Federal Contract. A one-month contract was approved for the month of April. A two-month

contract is anticipated for May and June. Thereafter contracts will be on a quarterly basis for the last two quarters of the calendar year.

The enrollment suspension was implemented and some of the tasks completed will be detailed shortly. Staff continues to monitor all expenditures, and it appears that, based on projections through December 31, California's PCIP will exceed the original $761 million allocation by a significant amount. She said MRMIB has been working very closely with CMS staff, which sees California PCIP fiscals on a weekly basis. While that was the original allocation for California, the state has been assured that, as long as CMS direction on new enrollment closure is followed, California will have sufficient funds to pay all claims, as necessary, through December 31of this year.

Call Center Report

Ms. Casillas reported on Agenda Item 8.b, the Call Center Report. The report shows the type of call volumes being received. There was an approximately 33 percent increase in calls for March, an additional 260 calls over what was received in February. The call volume increase is shown in the daily call report from March 26th. Most of the calls are from applicants and subscribers, as opposed to brokers and certified application assistants. Also outlined were a few examples of questions being asked by applicants. One question is whether applications are still being accepted and also what is the deadline for submitting applications.

Callers are being told that California PCIP is no longer taking new enrollment for and callers also are asking what other health care options are available. Staff has developed a call script to provide information on other available options, including MRMIP. Additionally, Ms. Casillas reported that some PCIP subscribers are calling to check that they will not be disenrolled and lose their health care coverage.

The top questions from broker and applicant assistants are the deadline for applications and whether a timely submitted application will continue to be processed if incomplete. She said the answer to the latter question is yes.

The PCIP Call Center Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_8.b._--_PCIP_Call_Center_Report_4-5-13.pdf

Tasks to Implement New Enrollment Suspension

Ms. Casillas presented Agenda Item 8.c, Tasks to Implement New Enrollment Suspension. She said her purpose in outlining some of the major tasks that have been undertaken by MRMIB staff is to gain input from the public and stakeholders on any additional tasks that should be added to the list.

Program partners Maximus and HealthNow Administrative Services were notified of the enrollment suspension, as was the Department of Public Health, Office of AIDS, which is a third-party payer for some PCIP subscribers. MRMIB also notified enrollment entities, certified applicant assistants and insurance brokers. Anthem Blue Cross, the MRMIP administrative vendor, was notified, as were the public and stakeholders.

The PCIP and MRMIB websites were updated, errata were developed for printed materials and modifications were made to the online fillable application, which is a joint application for both PCIP and MRMIP. The modification shows, when printed, that new enrollments are not being taken for PCIP.

Changes were also made to the screening process during the eligibility determination to ensure that potential applicants know about MRMIP, and the program is working to make those applications complete before sending them to MRMIP.

Staff also developed new text for the eligibility denial letters, noting the reason for the denial. Many applicants state they want only PCIP, so this language was developed for that purpose. However, we are reaching out to those individuals again to encourage them to allow their application to be moved to MRMIP.

Additionally, staff is evaluating the existing refund process for initial payments with applications received after March 2, because these payments may not be sufficient for MRMIP. Staff developed frequently asked questions that were posted to the PCIP website, and confirmed and monitored the process with Maximus for the portability exceptions to the enrollment suspension. The portability exception allows someone who was in PCIP in another state to submit an application that will still be processed.

Changes also were made to stakeholder outreach materials, newsletters, notices sent out on Twitter and Facebook, the toll-free line public service announcements, and billing statements to subscribers. Ms. Casillas indicated to the audience that, if MRMIB missed something, staff would like to know.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The PCIP Tasks to Implement New Enrollment Suspension document can be found here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_8.c_Tasks_to_Implement_New_Enrollment_Suspension.pdf

Enrollment Report

Ernesto Sanchez reported on Agenda Item 8.d, the Enrollment Report. A total of 906 new subscribers were enrolled in March, bringing the total number of subscribers to slightly more than 17,000. This may be the historical high point for PCIP because of the enrollment suspension. More than 23,000 persons have been served by PCIP in California since inception.

There were no major shifts in subscriber demographics in the program. The report also provides statistics on applications received before March 2, which are still being processed due to missing information from applicants. At the end of March, there were still 168 applications pending because of missing information.

Another new category in the report is those who applied after the enrollment suspension. These individuals will be contacted by the administrative vendor to determine whether they would like their application forwarded to MRMIP. The report also shows those who have declined this offer.

The report also shows national rankings, which lag a couple of months; the California PCIP continues to have the largest enrollment of any state in the nation.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The PCIP Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_8.d._--_PCIP_Enrollment_Report_for_March_2013.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 8.e, the Administrative Vendor Performance Report. The administrative vendor met all performance requirements for application processing, appeals processing, data transmission and toll-free line standards, as well as all quality and accuracy standards for eligibility determinations, application processing, adjudication of eligibility appeals, data transactions and premium payments. There were no benefit appeals during the reporting period.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The PCIP Administrative Vendor Performance Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_8.e._--_PCIP_Adm_Vendor_Board_Report_March_2013_data.pdf

Third Party Administrator Performance Report

Ellen Badley reported on Agenda Item 8.f, the Third Party Administrator Performance Report. She said Mary Watanabe, who typically presents this report to the Board, left MRMIB for a position at the California Health Benefit Exchange and is working with former MRMIB staffer Sarah Soto-Taylor on stakeholder engagement.

Ms. Badley pointed out that, concerning medical claims and pharmacy claims processing, there was one standard that the TPA missed slightly: processing clean claims within 30 days. That was because two claims were still in price negotiations with Stratos, the vendor used for high cost and out-of-network claims. Otherwise, all other performance standards were met. Additionally, all contracted standards for provider technical support and subscriber material production were met. There were no requests for IER (independent external review) or administrative hearings.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The PCIP Third Party Administrator Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_item_8.f.pdf

Other Program Updates

Ms. Badley reported on a site visit she made last week to the HealthNow Administrative Services offices in Pennsylvania. MRMIB manages the PCIP Program under a contract with the federal Department of Health and Human Services. As such, MRMIB has fiduciary responsibility to ensure that federal funding for PCIP is expended in accordance with the terms of a federal contract. In August of last year, CMS began an audit to assess MRMIB's compliance with PCIP statutory, regulatory and contractual requirements. Core areas of review included program involvement, disenrollment, premium billing and appeals, finances of the risk pool, and medical and pharmaceutical claims payments.

Objectives of the audit included determining the extent to which California was making eligibility determinations appropriately, making enrollment and disenrollment determinations appropriately, billing premiums accurately, adjudicating eligibility and coverage, maintaining a general ledger and supporting accounting records, keeping claims payments in according to PCIP requirements and complying with the terms of our federal contract.

Benefits provided through PCIP are administered from a contract with a third-party administrator, which is HealthNow Administrative Services. Unlike other MRMIB health care coverage contractors, HealthNow is not under the jurisdiction of either of California's two regulators, the Department of Managed Health Care or the Department of Insurance. As a result, MRMIB is solely responsible for oversight of the self-funded plan's operations, including assuring the vendor's compliance with contract requirements and business rules.

Ms. Badley said she believed that Ms. Rouillard made the initial site visit to HealthNow when PCIP operations began, to review the organization's operational infrastructure. Ms. Badley's follow-up visit was to view their offices and review some of the business rules and operational issues. Ms. Badley said her visit focused on four areas: customer service, claims payment, appeals and grievances, and contract reporting.

In the customer service area, she reviewed training materials used by HealthNow for its customer service operators and received an orientation on its training program. She reviewed call center scripts, monitored PCIP subscriber and provider phone calls, and reviewed the call documentation process. Additionally, Ms. Badley reported reviewing procedures for call escalation to supervisors, and looked at the real-time call monitoring system to ensure that call answer standards are met.

Concerning the complaint and appeal process, Ms. Badley reported meeting with HealthNow staff who handle those areas for MRMIB and reviewing a number of medical/pharmacy claims appeals files, several for IER (independent external review). She discussed with HealthNow staff how findings from overturned appeals by Maximus are used internally to improve process and reviewed their procedures.

On claims payment systems, she reported reviewing the training process for new claims examiners and the claims submission process, including the screens that are used to review and approve claims, as well as the processes used for escalating high-cost claims to various levels of approval.

In the reporting process, Ms. Badley reported reviewing all California PCIP monthly performance reports and the various systems the vendor uses to gather data and generate the reports.

In general, she reported finding no major causes for concern. She said it was very evident from her conversations with HealthNow call center and claims processing staff that they actively monitor operations against PCIP performance standards and performance guarantees. She described the staff as very open to showing her systems and processes, and in answering her operations questions. Many HealthNow staff has been with the organization for a number of years and has extensive experience in the field, although it was clear that the California PCIP was quite different from their usual clients, which are employers. This has made working with PCIP a new learning experience for HealthNow staff.

Chairman Allenby asked if there were any questions or comments from the Board or the audience.

Mr. Figueroa asked Ms. Badley whether the federal government auditor was present during her visit. Ms. Badley said a federal auditor would be sent separately.

Ms. Casillas said MRMIB staff thought it was necessary to go out and conduct an independent assessment and oversight in fulfillment of MRMIB's fiduciary responsibility. It had been some time since Ms. Rouillard's site visit when she was at MRMIB. Since the contract will end sometime next year and services will end December 31 of this year, it was time for an in-person review.

Mr. Figueroa asked whether the federal audit results were available yet.
Ms. Casillas said a second federal site visit is planned before the audit is completed. Ms. Krum said the audit has three components and only one has been completed. The auditors were delayed because of their work in other states, so postponed the other two sections of the California PCIP audit.

Chairman Allenby asked if there were any further questions or comments. There were none.

Mr. Figueroa announced that he would take over as chair for Mr. Allenby, who had to leave the meeting.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Mr. Sanchez reported on Agenda Item 9.a, the Enrollment Report. There were 209 new subscribers enrolled in MRMIP for March, bringing total enrollment to

more than 5,800. The MRMIP enrollment cap is 7,000 and there are no applicants on a waiting list.

The top 18 counties account for slightly more than 91 percent of enrollment. Mr. Sanchez noted that, with PCIP enrollment suspension effective March 2, MRMIP enrollment has increased a bit more than in past months due to a change in state law that allowed increased subsidy of MRMIP premiums.

For January and February, there was a 14 percent jump in applications, and in March, there was a 71 percent jump in the average number of applications coming in. In January, there was a 14 percent increase in enrollments. In February, there was a 32 percent increase, and in March, a 58 percent increase. Mr. Sanchez said that, in May, he would provide an estimate of when MRMIP's enrollment cap may be reached due to the increased monthly enrollment.

Mr. Sanchez indicated that MRMIB already has a document, entitled "Health Care Financial Resources List," for individuals who did not qualify for PCIP or MRMIP. A number of states have put this together; it provides resources from disease-specific organizations to help uninsured persons pay for the cost of their care. MRMIB staff is working to update that list and provide current information. Another option that will be a possible resource for some families is Share-of-Cost Medi-Cal.

Mr. Sanchez indicated that, as a result of recent budget hearings, staff has become aware that Health Access and some other stakeholders may have additional thoughts on options for the uninsured once MRMIP reaches its enrollment cap.

Mr. Figueroa asked if there were any questions or comments from the Board or audience. There were none.

Mr. Figueroa asked whether it was possible to make a copy of the resource guide available to the audience at a future meeting. Mr. Sanchez agreed. Mr. Figueroa suggested that audience members might have additional input.

Mr. Figueroa noted that in a two to four month period, MRMIP could be full and a waiting list established. Mr. Sanchez said the resource document was currently on the MRMIB website on the MRMIP tab.

The MRMIP Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_9.a._--_MRMIP_Board_Report_Summary_for_Apr_2013.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 9.b, the Administrative Vendor Performance Report. The administrative vendor met all performance standards for eligibility determinations and the toll-free line services.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The MRMIP Administrative Vendor Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_9.b._--_MRMIP_Adm_Vendor_Perf_for_Apr_2013.lnk.pdf

2012 Open Enrollment Report

Mr. Sanchez presented Agenda item 9.c, the 2012 Open Enrollment Report. Open enrollment is provided annually to allow MRMIP subscribers to change plans effective January 1 of the following year.

For the 2012 open enrollment, only 1.1 percent (62 persons) of subscribers requested a transfer, representing a slight decrease from the last two years, when the average was 1.2 percent. The total number of subscribers who responded to the survey increased to about 10 percent, and included subscribers who changed plans as well as subscribers who did not change plans. Survey results showed an increase again in subscriber satisfaction, up to about 95 percent. The satisfaction rate with providers remained the same, at about 97 percent.

Requests for plan changes were reflected in the report and typically showed subscribers moving from Anthem Blue Cross to Kaiser because of premium cost. Movement from Kaiser to Anthem Blue Cross typically reflected the subscriber's desire to see a particular provider.

The satisfaction survey results among subscribers who requested a health plan transfer showed 78 percent were satisfied with their health plan, more than 90 percent were satisfied with their personal doctor and 96 percent were satisfied with their specialist. For those changing health plans, the major reasons cited for changing were affordability (more than 35 percent). Mr. Sanchez noted the legislative action that allowed MRMIP premium reductions for 2013. Other reasons cited for requesting a plan change were a move to a new county of residence, limited choice of providers, dissatisfaction with medical care, and level of satisfaction with their doctors and specialists. He noted that through the survey, subscribers identified an interest in vision benefits.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The MRMIP 2012 Open Enrollment Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_item_9.c_2013_MRMIP_Open_Enrollment_Results_Transfer_and_Survey.pdf

Other Program Updates

Other Program Updates were not presented to the Board.

HEALTHCARE REFORM UNDER THE AFFORDABLE CARE ACT

Healthcare Reform Under the Affordable Care Act was not presented to the Board.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment Report

Larry Lucero reported on Agenda Item 11.a, the Enrollment Report. The report shows the most recent three completed months and the current enrollments for those months. The new enrollments were either applications processed prior to December 31, or AIM-linked infants that are currently an exception for enrollment.

There are no significant changes to demographic information and the top five counties represent 16 percent of enrollment or approximately 301,000 children. The report also includes health, dental and vision plan enrollment by percent. 1931-B screening that ends AER is now displayed in the report as an unavoidable reason for disenrollment and is among the top three reasons for unavoidable disenrollment for the most recent two months. The report also provides a new bar-chart depiction of the HFP children transitioned each month to Medi-Cal.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The HFP Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_11.a._--_HFP_March_2013_Summary.pdf

Administrative Vendor Performance Report

Mr. Lucero reported on Agenda Item 11.b, the Administrative Vendor Performance Report. The administrative vendor met or exceeded all six performance standards for March of 2013.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The HFP Administrative Vendor Performance Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_11.b._--_HFP_Adm_Vendor_QA_2013-03.pdf

2012 Federal Annual Report

Ms. Esajian reported on Agenda Item 11.c, the 2012 Federal Annual Report. Federal law requires that each state's Children's Health Insurance Program submit an annual assessment of its operations. The Healthy Families is California's separate CHIP Program. The report covers HFP and California's Medicaid expansion. The Department of Health Care Services was a contributor to this report.

The report, which covers the federal fiscal year beginning October the 1, 2011 and ending September 30, 2012, is an extensive document and this year's report totaled 172 pages. Ms. Esajian indicated that the Board packet included a summary and that the full version is available on the MRMIB website. Ms. Esajian said MRMIB staff also submitted a statutorily-required supplement to the Legislature and that this supplement can also be found on the MRMIB website.

This year's report, which will be the last one developed by MRMIB staff, highlighted major challenges and accomplishments. Of the challenges cited, the most significant was the political and administrative process that led to the enactment of legislation to transition HFP subscribers to Medi-Cal. That transition began on January 1, and to date a total of 554,832 children have been transitioned to Medi-Cal.

Another major challenge cited was the expiration of the Managed Care Organization Tax and the loss of its revenue that supports HFP, resulting in the funding shortfall that was discussed earlier in the meeting. Although these challenges were significant, accomplishments, nevertheless, were even more significant during the reporting period.

The Healthy Families Program 2010 Dental Measures Report recorded consistent improvement in both dental access and quality across nearly every data point, and further found that nearly 97 percent of HFP children who saw a dentist and received a preventive service. A point of pride was that nearly 91 percent of surveyed families reported that their child had a regular dentist.

The 2011 Consumer Assessment of Health Plans Survey and the Young Adult Healthcare Survey, which is also referred to as CAHPS and YAHCS, found that HFP families generally were satisfied with their plans, the care received and their doctors and specialists.

The Health-e-App public online application portal reported more than 100,000 public users and an additional 80,000 application assistant users. Together, these users applied for coverage for more than 345,000 children since December of 2010.

The FAR also requires goal-setting by the states. Ms. Esajian highlighted a couple of the goals that were set and reported. The program exceeded a prior year's goal of increasing the percentage of Medi-Cal eligible children enrolled by 4 percent. The program realized a 5 percent enrollment gain. The program met the prior year's goal of increasing the number of online applications received through Health-e-App, realizing a 5.1 percent increase. This accounted for 8,229 applications per month. Finally, program surpassed the prior year's goal of increasing access to mental health services by 5 percent over the previous year's rate, with a 12 percent improvement; this measure has climbed steadily over the prior three reporting periods.

In closing, Ms. Esajian acknowledged the MRMIB 2012 Federal Annual Report Team that included Melissa Ng, Jue Wang, Donna Lagarias, Tony Jackson, Dawn James, Theresa Gomez, Morgan Staines, Jenny Phillips, Lu Sanchez from the Department of Health Care Services, and MRMIB's data entry expert, Heidi Holt.

Mr. Figueroa asked if there were any questions or comments from the Board of audience. There were none.

On behalf of the Board, Mr. Figueroa thanked the FAR team. He said it appeared that it was another banner year for HFP and its work. He said it was his hope that

this final report is on the MRMIB website and is transmitted to legislative staff, along with MRMIB's normal monthly updates, so they can see all the good work, and the strong public access, reporting and public accountability and transparency this Board is known for in its programs.

Ms. Casillas said the report would be sent directly in the Board highlights, which is a summary of the Board meeting. She said the report would be transmitted, as statutorily required. She noted that it was the last FAR that MRMIB staff would develop and is required by CMS for the draw-down of Title 21 funds. This means DHCS will be the lead for next year's FAR. DHCS will fill out most of this information and MRMIB staff will just add to it, based on whatever programs MRMIB may still be administering with Title 21 funds.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The 2012 Federal Annual Report document is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_item_11.c_2012_Federal_%20Annual_Report.pdf

2012 Survey of Teen Health Care Experience

Tiffany Henderson reported on Agenda Item 11.d, the 2012 Survey of Teen Health Care Experience. In previous years the Managed Risk Medical Insurance Board administered the Youth Assessment of Health Care Survey. For 2012, the MRMIB staff developed a survey tool that placed more emphasis on measurement of teens' health care experience, rather than the risky behaviors that were addressed in the past YAHCS surveys.

The teen survey instrument consists of 24 questions addressing access to health care, confidentiality of health care, experience with health care, health and safety, and wellness of teens during 2011. Teens were given the option to choose more than one response for some of the questions, which is why some of the responses total less than or greater than 100 percent. Four questions from the 2011 YAHCS survey were included in the 2012 Teen Survey. However, some changes were made to the format of questions in the teen survey from those in the YACHS. For example, YAHCS asked teens whether a doctor talked to them about a variety of health topics, or risky behaviors, while the teen survey asked respondents to select from the list of topics. This change likely impacted survey results and the ability to accurately trend between two reports.

The report presents results from completed surveys obtained from 6,926 teen subscribers who were continuously enrolled in HFP for at least six months as of December 31, 2011. The overall response rate was about 40 percent. The greatest improvement observed was in response to the question asking whether teens were able to speak to a doctor alone. More than half of respondents indicated that they were able to speak to a doctor or other provider alone, without parents or other people in the room. This was an improvement of nearly 17 percent. Responses to the question asking whether doctors or other providers told teens their talks were confidential the majority of times improved from the last YACHS survey by 16 percent.

More than three-quarters of survey respondents, or about 83 percent, reported that they had been to see their doctor for medical or mental health care within the last year and less than one quarter of teens indicated that a community clinic, hospital, emergency room or other location was used for health care services.

While Asian language speakers are often grouped together throughout this report, there are significant differences in health care experience among Chinese, Korean and Vietnamese speaking teens. For example, Chinese/Korean speakers reported nearly doubled the rate of the English and Spanish speakers in obtaining health care by 25 and 20 percent, respectively. In addition, nearly three-quarters or 73 percent of Korean-speaking teens reported that their doctor did not tell them that what they discussed would be kept confidential. This is significantly higher than all the other languages, where about half said that their doctor did not talk to them about confidentiality. In the northern part of the state, respondents reported a delay in receiving mental health therapy and counseling care, or failure to receive such care, at nearly twice the rate for other regions, except for the southern coastal part of the state, which is about 18 percent. A final teen survey will be conducted this summer for comparison purposes.

Mr. Campana said it was both positive and striking that 50 percent of teens said they could talk to a doctor alone. However, the survey also shows that it seems doctors are still awkward in speaking to teens about sexual behaviors even though sexually transmitted diseases must be reported to public health departments. When the Centers for Disease Control breaks down, by age group, the percent of people that have been diagnosed with a sexually transmitted disease, the highest five years is between 15 and 19 years of age, higher than reported for people in their 20s or 30s. This is especially so when compared with statistics on 25- and 26-year-olds and indicates providers are still reluctant to talk about sex.

Mr. Campana also noted that the survey should list smoking separately. The significance of morbidity and mortality with tobacco use is still tremendously high. Not having this as a separate topic, like healthy eating, or weight or alcohol is something that is missing.

Shelley Rouillard commented that the response rate of 40 percent was impressive for the population surveyed. She asked how the questions were developed. Ms. Casillas said that she and Ellen Badley could address that question. Ms. Casillas said the survey was changed was because YAHCS and other surveys were asking this population the same questions repeatedly and the data was showing the same results repeatedly. MRMIB hoped to glean more information by first calling it a teen survey and then trying to better understand how many teens actually use the health care system independently and how many of them know how to access the system. Some of the responses were very interesting, and especially so when broken out by language. The new survey provided some new insights. Ms. Casillas said a smoking question was removed from the survey, but could be added if a second survey is conducted.

Ms. Casillas noted the focus on looking more at the teen consumer's experience, including how many of them knew how to navigate the system, how many knew that they had access to it, and how many of them actually took advantage of

having confidential conversations with their physicians. She noted that the use of $5 Target gift cards helped with the response rate.

Ms. Badley said a MRMIB staff member conducted a gap analysis and looked at all the various sources of information already available and available resource data about teen behavior. This was used to determine whether there was information or available research that could not already be found. She said, based on these findings, that she, Ms. Casillas, and former MRMIB staff Mary Watanabe developed the questions and then tested them on teenagers. The survey was administered by DataStat, which also provided some consulting on the questions. The survey was translated into several languages for the written survey but into English and Spanish only for the web version.

Mr. Figueroa said he did not know how often a survey sample of this size was conducted in California among adolescents. Mr. Campana said that CDC conducts the Youth Risk Behavior Survey every two years in three or four California communities. Ms. Casillas said the MRMIB Teen Survey would be an opportunity for a program like Medi-Cal to survey teens on their knowledge of what services are available to them, whether they are aware there are confidential services, how many of them access the services and whether they know how to navigate the system. Mr. Campana said another survey question could deal with accessing gynecological services. This could take the improved survey a step further.

Ms. Badley noted that the new survey did not attempt to ask respondents about differences among the various HFP plans. A representative sampling of subscribers was used to look at regional variation, but not at health plan affiliation. Ms. Wu asked whether there was an analysis by race and ethnicity.
Ms. Henderson said respondents were broken out by language and region, but not by race and ethnicity. Ms. Wu asked whether it would be possible to conduct this analysis. Ms. Casillas said the data was collected and could be broken out. She said that, if Board Members wanted any further break-out of data in tables, they should request that and staff would look into what is possible.

Mr. Figueroa asked if there were any further comments from the Board or the audience. There were none.

Mr. Figueroa complimented staff on the quality of the report.

The 2012 Survey of Teen Health Care Experience can be found here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_11.d_HFP_2012_Teen_Health_Care_Experience_Survey_Report.pdf

Other Program Updates

No other program updates were presented.

ACCESS FOR INFANTS AND MOTHERS(AIM) UPDATE

Enrollment Report

Mr. Lucero reported on Agenda Item 12.a, the Enrollment Report. A total of 849 new subscribers were enrolled in March for a current total enrollment of 6,171. There were no significant changes in data or demographic information.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The AIM Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_12.a._--_AIM_Mar_2013_summary.pdf

Administrative Vendor Performance Report

Mr. Lucero reported on Agenda Item 12.b, the Administrative Vendor Performance Report. The administrative vendor met or exceeded all performance and quality standards for March 2013.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The AIM Administrative Vendor Performance Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041713/Agenda_Item_12.b._--_AIM_Adm_Vendor_Perf_Mar_2013_Summary.pdf

Other Program Updates

Other Program Updates were not presented to the Board.

The meeting public session was adjourned at 1:04 p.m.